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Dear Minister,

Understanding and managing the risk of respiratory infections in healthcare

Your correspondence with Tim Farron MP (Re Ms Anne McConway) has been shared with us as the consortium of scientific and professional bodies who provided much of the evidence to the COVID-19 Inquiry as invited core participants. Having read your letter we are concerned that you have been wrongly advised about the most appropriate scientific evidence on the transmission of Covid-19. As the Minister responsible for the response to COVID-19, but also infectious diseases more generally, this is a matter of great concern.

Despite your reasonable suggestion that we should refer to the latest scientific evidence, your letter references outdated information and a publication from 2020: <https://www.gov.uk/government/publications/sars-cov-2-transmission-routes-and-environments-22-october-2020>.

Your advisors should also be aware that Baroness Hallett, Chair of the UK Covid-19 Public Inquiry, published her report for Module 1 of the Inquiry on 18 July 2024. This unequivocally stated that the “primary routes of transmission for pandemic influenza and coronaviruses are airborne and respiratory”. In Modules 2 and 3, experts including Professor Cath Noakes, Professor Clive Beggs, Dr Gee Yen Shin, Professor Dinah Gould and Dr Ben Warne brought together the latest scientific evidence.

You are correct that Dr Lisa Ritchie gave evidence that she personally believes the droplet route to be the predominant mode of COVID-19 transmission “Q. Is that still your position in this Inquiry today, after all the evidence we've heard: that the primary mode of transmission for Covid-19 is droplet and contact? A. That is my

position.” (However, Dr Ritchie also confirmed that her role is not and was not to determine the scientific evidence, but “translating the science that we were being given”).

All other witnesses whether expert or representing public bodies accepted the significant role in of airborne transmission of COVID-19.

Regardless of whether COVID-19’s predominant mode of transmission is airborne or droplet to the extent that the distinction is helpful, this does not change the law that binds undertakings including those for public bodies. The relevant law is found in the Control of Substances Hazardous to Health Regulations 2002 (COSHH). Reflecting those Regulations and therefore legally binding, the Approved Code of Practice, states that the risk must be assessed and, “Exposure through all routes must be considered.”

As you point out, airborne infection is a known route of transmission. In the application of COSHH to healthcare settings for the protection of employees, workers, patients and visitors, the Health and Safety Executive (HSE) statutory guidance is unambiguous in stating the duty is to control the risk of infection, through whatever route, so far as reasonably practicable.

While UK IPC guidance is made to assist health professionals to put into effect the principles under the [Code of Practice](#) under the Health and Social Care Act 2008, COSHH and its regulations are legally binding and take precedence over any Infection Prevention and Control guidance. Multiple iterations of the IPC guidance remind users that this is subject to Health and Safety duties.

Given the current 'quad-demic' of four airborne winter illnesses (flu, Covid, norovirus and RSV) we are sure you will want to tackle and reduce as far as possible the ongoing and unacceptable levels of hospital acquired infections both for patients and healthcare workers. These continue to hamper your commitment to give NHS patients the quality of care they deserve and also reduce the burden of ill health caused by Long Covid and other post-viral sequelae.

Throughout the pandemic and to this day, healthcare professionals and managers have struggled to reconcile multiple sources of guidance with statutory health and safety duties. The Health and Safety Executive, with the support of the Advisory Committee on Dangerous Pathogens previously published (2005) guidance (*Biological agents: Managing the risks in laboratories and healthcare premises*) which related COSHH to healthcare guidance and policies. This link appears to be inadvertently broken when the 2008 Act was passed.

There is a crucial opportunity for you to support the National Health Service, the resilience of its workforce and public health by revisiting the Code of Practice guidance under Criterion 10 (Occupational Health) to make explicit links to good practice under COSHH. Criterion 10 requires registered providers to “have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control”.

An update and revision of the *Biological agents: Managing the risks in laboratories and healthcare premises* under the joint auspices of your Department and the HSE could encapsulate and disseminate many of the lessons of the pandemic, as well as differentiating between the primary role of IPC (to protect the health service user) and the more general function of COSHH to protect the workforce, as well as the service user.

Given the Government's recent statement on the Covid Inquiry Module 1 report, we strongly recommend that HSE and its parent Department explore routes to ensure more joined up working in the management of biological agents under COSHH in the control of infections in healthcare. For this reason, we are copying our response to Sir Stephen Timms in the hope that this will catalyse the interdepartmental working required to build future resilience in accordance with the Government's stated objectives.

Yours Sincerely



Dr Barry Jones BSc MBBS MD FRCP

Chair

On behalf of the CATA Executive Team:

Ms Kamini Gadhok MBE, Vice Chair, ex CEO RCSLT

Professor Kevin Bampton, CEO BOHS

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cc Sir Stephen Timms Minister of State (Department for Work and Pensions)

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